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Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development

Mental health and human rights

Report of the United Nations High Commissioner for Human Rights*

Summary

In accordance with Human Rights Council resolution 36/13, a consultation on human rights and mental health was held in Geneva on 14 and 15 May 2018. Participants discussed the topic of mental health as a human rights issue and agreed that the situation could be improved through system-wide strategies and human rights-based services to combat discrimination, stigma, violence, coercion and abuse. The present report contains a summary of the discussions, as well as conclusions and recommendations from the consultation.

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I. Introduction

1. The Human Rights Council, in its resolution 36/13, requested the United Nations High Commissioner for Human Rights to organize a consultation to discuss all relevant issues and challenges pertaining to the fulfilment of a human rights perspective in mental health, the exchange of best practices and the implementation of technical guidance in that regard.

2. The consultation took place on 14 and 15 May 2018 and benefited from the participation of a wide range of stakeholders, including Member States, United Nations agencies, funds and programmes, special procedures and civil society, including persons using mental health services, persons with mental health conditions and persons with psychosocial disabilities, and their representative organizations. Participants discussed mental health as a human rights issue, and how to promote human rights through system-wide strategies and human rights-based services and support, and the exchange of good practices to combat discrimination, stigma, violence, coercion and abuse in the context of mental health.

II. High-level opening

3. The President of the Human Rights Council, Vojislav Šuc, introduced the objective of the consultation, which was to discuss challenges pertaining to the fulfilment of human rights in mental health and the exchange of good practices. He thanked Portugal and Brazil for their leadership in organizing the consultation and extended his gratitude to civil society, particularly to persons using mental health services, persons with mental health conditions and persons with psychosocial disabilities, for their valuable participation.

4. The Chair of the Indonesian Mental Health Association, Yeni Rosa Damayanti, stressed that the discussion on mental health and human rights must be centred on inclusion of the rights of persons with psychosocial disabilities, which went beyond the traditional mental health approach narrowly focused on treatment. She listed barriers that persons faced, in both the global South and the global North, in accessing housing, employment, social protection and the right to political participation. Those barriers were made worse by stigma and discrimination embodied in laws and policies and reflected in attitudes held by the authorities, employers and the public at large. She emphasized that the current response and growing trend around the world towards medication and institutionalization generated further violations, which were compounded by the loss of legal capacity, ultimately leaving persons with psychosocial disabilities further behind. She expressed alarm about the ongoing process within the Council of Europe of drafting an additional protocol to the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine (the Oviedo Convention) to legitimize involuntary treatment of persons with psychosocial disabilities, in violation of the Convention on the Rights of Persons with Disabilities, in a deliberate move away from the advances made to ensure human rights in mental health, such as the QualityRights initiative of the World Health Organization (WHO). She stressed the importance of the participation and the voices of people with psychosocial disabilities themselves, and their representative organizations, in the discussions, saying: "No talk about mental health should exclude us ever again".

5. The United Nations High Commissioner for Human Rights, Zeid Ra'ad Al Hussein, stated that the right to the highest attainable standard of health was fundamental to human dignity, and that there was no health without mental health. Yet harmful stereotypes had an impact on the participation and inclusion of persons on account of actual or perceived mental health conditions, and could lead to arbitrary detention in institutions that were often the locus of abusive and coercive practices potentially amounting to torture. He deplored institutionalization as an inadequate response at all levels for children and adults with disabilities and called for the elimination of practices such as forced treatment, including forced medication, forced electroconvulsive treatment, forced institutionalization and segregation. Instead, he called on States to ensure access to a range of support services

within the community, including peer support, and reminded participants that the Convention on the Rights of Persons with Disabilities offered the legal framework to uphold the rights of people with psychosocial disabilities — including the exercise of legal capacity, free and informed consent, the right to live and be included in the community and the right to liberty and security, without discrimination. He welcomed the participation of rights holders, with their real-life experience, and called for a strengthening of the support for the framework provided by the Convention, which had already generated change in restoring respect for the autonomy, choices and rights of persons with psychosocial disabilities.

6. The Director-General of the International Labour Organization, Guy Ryder, expressed his organization's commitment to join the collective efforts to promote mental well-being and the right to work of persons with mental health conditions. He pointed to stereotypes and discrimination within the workplace due to lack of awareness on the part of employers and recruiters, which led to exclusion and lower rates of participation in employment. He described the work that the International Labour Organization carried out with Member States and enterprises to identify good practices contributing to a more inclusive work environment, including through the provision of reasonable accommodation. He announced that the International Labour Conference would negotiate a new instrument against violence, stigmatization, discrimination and harassment at work.

7. An Assistant Director-General of WHO, Dr. Svetlana Akselrod, underscored the importance of prioritizing, in the discussions, the voices of people with real-life experience. Referring to the constitution of WHO, which referred to mental health, she admitted that little progress had been made to advance mental health as a human right. She affirmed that people with mental health conditions and psychosocial disabilities lacked access to quality services that were respectful of their rights and dignity, and faced marginalization, frequently being institutionalized and more likely than the general population to die prematurely. She drew attention to the adoption by the World Health Assembly of a mental health action plan guided by the Convention on the Rights of Persons with Disabilities and other international human rights instruments. She referred to the QualityRights initiative, which had resulted in a significant shift in human rights awareness by mental health workers, decreased violence and abuse, and increased empowerment of people with mental health conditions and psychosocial disabilities.

8. The Permanent Representative of Portugal to the United Nations Office and other international organizations in Geneva, Pedro Nuno Bártolo, highlighted mental health as an important frontier of human rights, and welcomed the transformative nature of Human Rights Council resolution 36/13 on mental health and human rights, which reflected States' individual responsibilities within their societies as well as the collective responsibility to uphold the principles of humanity, dignity and equality at the global level. The resolution broke new ground, by moving away from the perpetuation of violations through arbitrary institutionalization, exclusion and segregation and moving towards a human rights-based approach. Collaborative efforts were needed to address the discrimination, stigma, violence, abuse, torture and degrading treatment or punishment that continued to have an impact on persons with mental health conditions and persons with psychosocial disabilities. He highlighted the support from the United Nations system, particularly the Office of the United Nations High Commissioner for Human Rights and WHO, including the latter's QualityRights initiative, as well as the work by the three special rapporteurs on the panel, and reaffirmed the new approach to mental health, which was based on human rights. He said that mental health conditions were just one incident away from each one of us, and yet there was still a major stigma attached to them. He concluded by recalling the golden rule of all civilizations: do unto others as you would have them do unto you, and do naught unto others that you would not have them do unto you.

9. The Permanent Representative of Brazil to the United Nations Office and other international organizations in Geneva, Maria Nazareth Farani Azevêdo, was hopeful that the consultation could leverage efforts to ensure that mental health policies and practices were aligned with human rights law. She affirmed that the right to mental and physical health implied negative and positive obligations, including access to universal health coverage, and the adoption of non-discriminatory laws, policies, practices and responses to

ensure the social determinants of health. She recalled that Brazil, Portugal and WHO had been partnering through different initiatives to raise mental health as a human rights priority for persons with mental health conditions and psychosocial disabilities.

10. During the interactive dialogue, representatives of the European Union, Brazil on behalf of the Foreign Policy and Global Health group, Colombia, Ecuador, Australia, the Plurinational State of Bolivia, the World Network of Users and Survivors of Psychiatry, Disability Rights International, the International Disability Alliance and the Parliamentary Assembly of the Council of Europe took the floor. Brazil called for concerted efforts to support the paradigm shift away from coercion and exclusion. Colombia, Australia and Disability Rights International highlighted the need to take into account the intersecting identities of individuals — which compounded the disadvantage and discrimination facing women and girls, children, older persons, lesbian, gay, bisexual, transgender and intersex persons, indigenous peoples, persons on a low income or living in poverty and those living in rural communities. The Plurinational State of Bolivia suggested that new ways of thinking and promoting health could be derived from the traditional knowledge and values of indigenous peoples to strengthen the harmony of the individual within the family and the community. The representative of the Parliamentary Assembly of the Council of Europe announced the Assembly's continued opposition to the drafting of the additional protocol to the Oviedo Convention concerning "the protection of human rights and dignity of persons with mental disorder with regard to involuntary placement and treatment", joining other high-profile human rights bodies. She called for its withdrawal, as it was contrary to the Convention on the Rights of Persons with Disabilities; that was supported by the World Network of Users and Survivors of Psychiatry and the International Disability Alliance. The World Network of Users and Survivors of Psychiatry warned against any reform initiatives that reinforced the status quo by continuing to place psychiatry and the mental health system at the centre of power, and stressed the need for an approach that restored, and was centred on, the voices and rights of persons with psychosocial disabilities.

III. Summary of the proceedings

A. Setting the scene: mental health as a human rights issue

11. The panel, composed of three special rapporteurs, a representative of Transforming Communities for Inclusion-Asia and a representative of the United Nations Children's Fund (UNICEF), referred to the human rights abuses within mental health settings, ranging from discrimination and stigmatization to overmedicalization and the use of force. All speakers called for the abolition of those practices and concurred that the right to mental health could be promoted only in supportive and enabling environments at home, at school, in the workplace or in health-care settings that addressed the underlying determinants of health, such as poverty, discrimination, social exclusion and violence, which disproportionately affected persons with disabilities. All speakers stressed that persons using mental health services and persons with psychosocial disabilities, including children, women, and those living in poverty or belonging to other marginalized groups, must be the principal interlocutors in discussions about their rights, and that States had an obligation to take into account their opinions in all matters affecting them directly or indirectly, including the development of mental health services.

12. The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Dr. Dainius Pūras, exposed the pervasive stigmatization, overmedicalization and use of force that resulted in violations of the human rights of users of those services and persons with psychosocial disabilities worldwide. He referred to the deep power asymmetries, the predominance of the biomedical model and the biased use of knowledge, within psychiatry and mental health, as obstacles to the realization of rights. He asserted that the status quo was maintained by the concepts of dangerousness and of medical necessity to "fix a disorder", which was not supported by modern evidence and continued to justify the use of non-consensual measures as "exceptions".

13. The Special Rapporteur on the rights of persons with disabilities, Catalina Devandas Aguilar, agreed that coercion and exclusion had become the rule in the majority of mental health systems, particularly in developed countries, and that involuntary interventions, such as electroconvulsive therapies, psychosurgery, forced sterilization and other invasive, painful and irreversible treatments, continued to be permitted, contrary to the Convention on the Rights of Persons with Disabilities. In that regard, she expressed her opposition to the initiative of the Council of Europe to draft an additional protocol to the Oviedo Convention that would serve to legitimize those coercive practices, and called upon member States of the Council of Europe to stand against it, as it represented an unacceptable backward step in rights protection. She drew attention to good practices and tools from within and outside the health system that offered solutions and support in crisis or emergency situations, which were respectful of medical ethics and of the human rights of the individual concerned, including of their right to free and informed consent. They included programmes for personal assistance, psychosocial support and housing, which reduced the risk of institutionalization and of being subjected to physical and sexual violence. She recalled that the participation of persons with disabilities themselves was an essential precondition for development based on human rights.

14. The Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Nils Melzer, joined the other special rapporteurs in condemning as unlawful forced institutionalization and any detention based on disability and noted that it may amount to torture and ill-treatment. He drew attention to the fact that people with psychosocial disabilities often lost their legal capacity, causing them to fall below the radar of legal purview, including within court proceedings, which might result in "voluntary" institutionalization through the consent of a third party, in being subjected to forced medication for restraint or punitive purposes, and in other intrusive treatments such as forced sterilization, abortion, contraception, or electroconvulsive therapy, which might also amount to torture and ill-treatment.

15. Bhargavi Davar, of Transforming Communities for Inclusion-Asia, drew particular attention to the situation in the Asia-Pacific region, indicating that the traditional mental health system and its biomedical approach had been imported through colonial frameworks (e.g. incapacity laws and guardianship) and had been sustained through the growing trend of pills and institutions fuelled by pharmaceutical interests. She warned that such practices and mental health laws had led only to greater violence and violations, through new forms of coercion and forced institutionalization. She recalled that legal capacity, liberty, equality, non-discrimination and inclusion were rights belonging to everyone, as enshrined in human rights instruments, and that the Convention on the Rights of Persons with Disabilities called for all rights for all persons with disabilities, without exception. She underscored that old practices led only to old outcomes, and for innovation to emerge, new approaches must be adopted. She affirmed that reforming mental health and incapacity laws was not enough, and called for their repeal and for a moratorium on new mental health laws. She cited examples of emerging practices and called for further support for new community practices, guidance and pilot programmes for deinstitutionalization, socially innovative caregiving within communities, and a shift of mentality in all services linked to development and human rights. She called for persons with psychosocial disabilities to be at the centre of, and to lead, that transformation.

16. Nina Ferencic, of UNICEF, recalled that mental ill-health was often a direct consequence of violence, emotional neglect and ill-treatment experienced during childhood, including due to institutionalization, and that it had a disproportionate impact on children with disabilities, whose families often lacked information and support to raise their child at home. She expressed concern about the criminalization, control and policing of mental health, which had no parallels in other areas of health. She highlighted commonalities with juvenile justice, where the majority of incarcerated youth had mental health or substance use disorders and had experienced traumatic victimization, such as physical abuse, domestic violence or neglect. She pointed to the need to implement approaches that would reduce incarceration and provide youth with access to a broader range of measures to help them grow and develop in the community. She suggested working across health, education, social protection and legal systems and directly with children, youth, parents, teachers, care

providers, schools and communities to raise awareness about mental health and facilitate support for children.

17. During the interactive dialogue, representatives of Lithuania and of Autistic Minority International, Support-Fundació Tutelar Girona, Mental Health Europe, Salud Mental España and Human Rights Watch took the floor. Lithuania welcomed the consultation and called for continued efforts to be made towards a human rights-based approach in mental health. The comments and questions that followed touched on: (a) the fact that the absolute prohibition, in the Convention on the Rights of Persons with Disabilities, of institutionalization applied equally to autistic children and other people on the basis of "health" reasons; (b) the need to ensure that all approaches were centred on the views of people with psychosocial disabilities themselves; and (c) the fact that practices that were compliant with the Convention could precede and trigger legal reform and should be encouraged, including through the training of professionals. Echoing the comments of the Special Rapporteur on the rights of persons with disabilities, representatives of several organizations expressed opposition to, and called for the withdrawal of, the draft additional protocol to the Oviedo Convention.

18. In response, the panellists welcomed the support for the paradigm shift, acknowledged persistent barriers, including traditional psychiatric practices, and called for laws and attitudes to be changed, as well as for the eradication of detention of children on the basis of their mental health or any health condition.

B. Improving human rights in mental health through system-wide strategies

19. Dr. Michelle Funk, of WHO, elaborated on the WHO QualityRights initiative to advance the human rights-based approach to mental health and the work undertaken by WHO with countries to: build capacity on human rights and mental health; transform those systems to promote quality and rights, including by supporting civil society; and support policy and legal reform that was compliant with the Convention on the Rights of Persons with Disabilities, particularly in relation to legal capacity, liberty, community inclusion and the elimination of violence. She emphasized that the QualityRights tools had had a significant impact in changing attitudes, practices and service delivery — for respect of the right of the individual to make his or her own decisions, to provide people with information and choice about treatment options, and to end forced treatment, seclusion and restraint. She shared results that illustrated reductions in violence, an increased use of support instead of force, and a reorientation of services towards a recovery approach. WHO was developing a best practice guide on community services that operated without coercion, supported recovery, and promoted autonomy and inclusion.

20. Dr. Vincent Girard, of the Agence régionale de santé Provence-Alpes-Côte d'Azur, described the "Housing First" programme, which had been operating in France for over 20 years, supporting the inclusion of persons with psychosocial disabilities. Although France had the second-highest mental health budget in Europe, human rights violations persisted: psychiatric coercion was on the rise (with a 15 per cent increase since the 2011 law reform, the objective of which was to strengthen the rights of forcibly hospitalized patients), and nearly 45,000 people with psychosocial disabilities were living in the streets, and 25,000 in prisons. He explained that the "Housing First" model did not condition access to housing on the acceptance of care or on restriction of the consumption of drugs or alcohol, that the person concerned was supported by a team, which included peer workers and was coordinated by a social worker, and that the psychiatrist was not the one in charge. He said that the intervention was effective because it focused on all aspects of an individual's needs, not on reducing symptoms, and that the results of the programme showed savings in terms both of resource expenditure and of respect for human rights, by decreasing and preventing hospitalization. He agreed that scientific research and projects must be used to inform and reform policy in regard to the misconceptions of dangerousness and of medical necessity to "fix a disorder", which were not supported by modern evidence.

21. Dr. Alberto Minoletti, of the University of Chile, provided an overview of mental health reform in Chile from 1990 to 2018, outlining the main achievements, which had included increased availability, accessibility and quality of community mental health services, and social inclusion for persons with psychosocial disabilities. Over the years, there had been a reduction in the number of inpatient stays in mental health facilities, as well as a reduction in levels of coercion, abuse and violence within those services. Legal reform measures had included protection of the right to informed consent for treatment and research, restrictions on involuntary hospitalization, prohibition of psychosurgery, and the establishment of a monitoring agency to protect the rights of persons using mental health services. While challenges remained, those changes had increased inclusion in the community with comparatively few resources.

22. Dr. Roberto Mezzina, of the Azienda Sanitaria Universitaria Integrata, in Trieste, described the mental health reform in Italy, which had led to a deinstitutionalization process involving the closure of psychiatric hospitals (between 1978 and 1999) and forensic hospitals (in 2017). Law No. 180 of 1978 had recognized human rights as a key tool in mental health care, which had led to a shift within psychiatry and to the wider provision of welfare and services in the community, centring on the person rather than the diagnosis. That approach required proactive and assertive care, rapid responses to crises, open doors, no restraint, and continuity of care and practices following the principles of choice, personalization and rights, the objective of which was to promote shared responsibility, dialogue, recovery, and early support. He described the model operating in the Veneto region, which had an assessment and emergency unit placed within the general hospital as a point of first contact, and a home treatment team that applied the principle of open dialogue. Some 94 per cent of the mental health budget was spent within the community. It facilitated the tailoring of recoveries in an individual way, within an overarching approach, which emphasized that liberty was not the outcome of care, but rather a precondition for it. He highlighted the need to ensure the social determinants of health in order to achieve equality and overcome exclusion, which included stability in connection with one's home, work, income, social support and relationships. He stressed the importance of involving stakeholders, including service users, fostering therapeutic alliances that respected individuals' will and preferences, and prioritizing participation as central to democracy and social justice.

23. A human rights expert, Dr. Amalia Gamio, referred to the persistent gap in terms of respect for human rights in the context of mental health care, owing to prejudice and stigma, which increased the risk of violations such as forced treatment, including forced sterilization. She remarked that insufficient attention was paid to equal recognition before the law, as enshrined in article 12 of the Convention on the Rights of Persons with Disabilities. She called for urgent structural reform, to explicitly prohibit institutionalization and forced treatment, to develop community-based strategies, and to ensure resources, capacity-building and monitoring at all levels. She shared a positive example of cooperation by more than 30 organizations, which had led to the successful withdrawal of the mental health bill in Mexico because it would have continued to allow involuntary internments. She commended the Political Constitution of Mexico City, which explicitly recognized the legal capacity of all individuals and which would come into force in September 2018.

24. During the interactive dialogue, representatives of the Plurinational State of Bolivia, of Ecuador, and of civil society — namely the Citizens' Commission on Human Rights, We Shall Overcome and Salud Mental España — took the floor. The delegates from the Plurinational State of Bolivia and from Ecuador shared good practices from their respective countries to promote human rights in mental health care, which included prioritizing the quality and accessibility of services within the community, and eliminating social exclusion through participation in decision-making processes. Speakers reiterated the call to shift from the biomedical model and deprivation of liberty in mental health care, to increased focus on the root causes and social determinants to promote a recovery approach. They also called for increased attention to be paid to the multiple and intersecting forms of discrimination operating within mental health systems, which had a disproportionate impact on women with psychosocial disabilities. The representative of We Shall Overcome shared the example of the introduction of medication-free wards in Norway, an initiative that had

been proposed by user/survivor organizations and was now established as part of the State health-care system in all regions of Norway. The medication-free alternative did not threaten community-based inclusion or support, and was aimed at ensuring that persons could choose and receive support without being subjected to forced drugging, thus maintaining their agency and self-determination. She emphasized that that measure, however, could not replace wider legal reform to abolish forced treatment.

25. In response, panellists agreed that more focus was needed to address the social determinants that had an impact on mental health. Improving access and support were essential, but the use of force and coercion must simultaneously be addressed to promote inclusion and a recovery-based approach — including ensuring access to justice and seeking redress for violations. The changing role of psychiatrists was also raised; they had an important role to play in developing innovative practices, yet many remained resistant to the human rights model, which placed the individual at the centre as an expert in his or her own right. Panellists referred to the need for political will for a human rights-based approach to be adopted in mental health.

C. Human rights-based services and support to improve the enjoyment of human rights in the context of mental health

26. Olga Runciman, of Psycovery, introduced the work of the Hearing Voices Network, a movement working outside of psychiatry in 33 countries. She referred to the case of an individual to illustrate how psychiatry silenced and dominated by forcing one into a diagnosed role. The case concerned a woman subjected to treatment and medication without her consent; no steps had been taken to explore the causes of distress linked to trauma she had experienced in her past, rather, the focus was on her diagnosis of schizophrenia and the voices she heard. Ms. Runciman concluded that the Hearing Voices movement and network allowed individuals to find their own voice, and allowed fellow voice hearers and peers to help one another find meaning and understanding. The network encouraged activism and raising public awareness about the harm psychiatry could cause.

27. Dganit Tal-Slor described the experience of the New York social service agency Community Access, whose mission was to expand opportunities for people living with mental health conditions to recover from trauma and discrimination and to advocate for affordable housing, education, vocational training and healing-focused services. Community Access followed a person-centred approach that promoted self-determination, harm reduction, recovery, dignity and human rights. It had been instrumental in developing the peer movement in New York, and in integrating peers as advocates into practically all programmes on mental health. It had also worked in police precincts to develop crisis intervention training for police officers to enable them to better understand the challenges and needs of individuals in crisis. The aim of the agency was to work with the City of New York to develop mental health teams composed of peers and social workers as first responders to emergency calls. Furthermore, the agency was working with the City and the State of New York to develop alternatives to hospitalization and emergency visits, and the City had initiated "respite centres" run and operated by peers. Ms. Tal-Slor said that most of the agency's service recipients lived in poverty, many without food security or homes, and that the system failed to recognize the need for a holistic approach to supporting and empowering individuals living with mental health conditions, as the front-line approach remained medicalization, forced treatment in hospitals, and imposing conditions of "treatment compliance" for services, including access to housing. She observed that funding for medication and hospital visits was more easily provided than funding needed for inclusion in the community through housing and job training.

28. Michael Njenga, of the African Disability Forum, affirmed that article 12 of the Convention on the Rights of Persons with Disabilities, and general comment No. 1 (2014) on equal recognition before the law, of the Committee on the Rights of Persons with Disabilities, identified peer support as a form of supported decision-making for the exercise of legal capacity. Peer support valued lived experience, as peers held knowledge and expertise to support others going through difficult times in their lives, and it thus helped advance autonomy during times of emergency decision-making, and was an integral part of

recovery-based services and inclusion in the community. Mr. Njenga described the work of Users and Survivors of Psychiatry in Kenya — in documenting peer support as a tool for supported decision-making, boosting agency and autonomy for individuals as it provided a safe space for sharing of experiences and information, developing collective knowledge, and providing advice and support in risk-taking. He said that peer-support group meetings might entail discussion of day-to-day decisions and decisions with legal and financial consequences, and that members discussed medication and treatments, were informed about their human rights and were supported in claiming them (e.g. refusing treatment). He noted that, over time, members became more assertive about making their own decisions, and regaining control of their lives as empowered agents, rather than as objects of treatment. He mentioned the commitment by the Government of Kenya to scale up the operation he had described, to establish peer-support groups across the country, motivated by the findings of Users and Survivors of Psychiatry in Kenya.

29. Sashi Sashidharan, of the University of Glasgow, celebrated the paradigm shift anticipated by the Convention on the Rights of Persons with Disabilities, but regretted that there had been little progress in the area of mental health. Nonetheless, he argued that all actors involved could carry out microtransgressions of the current paradigm by engaging in practices and experiences that challenged it. He described the experience of employing persons who had real-life experience of mental health problems as part of every community mental health team, with equal pay, which made a significant difference to integrating peer support, establishing advanced directives and ensuring choice of treatment. Furthermore, Governments could set simple targets for services, in order to reduce admissions under their mental health act. Mr. Sashidharan highlighted the creation of crisis-resolution home treatment teams, available 24 hours and 7 days a week, to support people in crisis at home, which had served to decrease the number of compulsory admissions. He commended the example from Norway on medication-free alternatives. He argued that the most difficult challenge was to reform the current practice of forensic psychiatry, as there was no evidence to support its effectiveness, despite 18 per cent of mental health resources being spent on locking people up in psychiatric care.

30. During the interactive dialogue, representatives of the World Network of Users and Survivors of Psychiatry, the Indonesian Mental Health Association, the Centre for Inclusive Policy, Autistic Minority International and We Shall Overcome, and of the Plurinational State of Bolivia and the United Kingdom of Great Britain and Northern Ireland, took the floor. The issues raised included: the benefits of peer support detached from the mental health system; psychiatry as the gatekeeper for access to public services, such as housing; how to "demedicalize" resources invested in support services in the community that did not need to be attached to the mental health system; and the need to confront discrimination against autistic persons based on pathologization and diagnosis leading to prevention measures and therapies that denied the preservation of and respect for autistic identity. The Plurinational State of Bolivia addressed concerns about the funding of medicalization, and about the biomedical perspective, and the United Kingdom stressed the urgent need to tackle stigma, abuse, forced treatment, and unlawful or arbitrary institutionalization. In the context of the draft additional protocol to the Oviedo Convention, the withdrawal of Portugal from that process was commended, and a call was made to other States to follow that good example for fulfilment of the obligations enshrined in the Convention on the Rights of Persons with Disabilities.

31. Panellists gave various responses concerning psychiatry as a gatekeeper to services, emphasizing that psychiatry should be one choice among many. Panellists warned that peer work organized by psychiatrists risked legitimizing traditional treatment and might remove power from the peer movement, and emphasized the need for approaches that contributed to empowering individuals. It was affirmed that the priority should be to ensure autonomy and dignity, restoring voice, power and choice to persons with psychosocial disabilities, and also that there was a need to shift from a model of containment to a model of recovery and inclusion in mental health. Panellists presented positive examples of practices regarding peer support and peer certification, and observed that peer support helped overcome the trauma linked to having been forcibly removed from the community (through forced hospitalization). They noted the positive impact of peer support in liaising with police and hospital staff to prevent such trauma. Speakers highlighted the lack of research and

evidence about the benefits of force in psychiatry, and the fact that, on the contrary, several findings documented negative experiences and lasting anger by those subjected to forced treatment. It was concluded that human rights violations still took place in mental health settings, which caused inequalities to proliferate, and that that was compounded by intersecting identities. Any successful reform would require a change of heart within psychiatric and clinical practice to move beyond the biomedical model of psychiatry.

D. Improving practices to combat discrimination, stigma, violence, coercion and abuse

32. The panel was composed of representatives of the United Nations Population Fund (UNFPA), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the International Committee of the Red Cross (ICRC), Human Rights Watch, and Akershus University Hospital, Norway. The panellists highlighted the centrality of mental health to general health, human rights and dignity. All panellists agreed that in order to promote inclusion and mental health, multiple forms of discrimination and inequality must be addressed — relating to youth, women, persons living with HIV/AIDS, persons living in poverty, persons living in rural regions, persons with disabilities including persons with psychosocial disabilities, and other intersecting identities. The panellists promoted a people-centred approach to empower communities as agents of change, by including rights holders in the design and implementation of programmes and services and in the training for them.

33. Monica Ferro, of UNFPA, emphasized that mental health was a component of sexual and reproductive health and rights, and that mental health issues could develop due to lack of choice in reproductive decisions and could arise in connection with the psychological dimensions of conception, pregnancy, childbirth, post-partum care, and events relating to abortion, miscarriage, HIV/AIDS and female genital mutilation. She suggested that mental health should be integrated into all sexual and reproductive health and rights policies, strategies, programmes and statistics. She referred to the determinants of mental health, and emphasized that gender discrimination often led to detrimental impacts on women's rights; for example, the increased likelihood of women being subjected to sexual violence linked to the prevalence of post-traumatic stress disorder suffered by women; women's higher rates of diagnosis with depression, compared to men with identical symptoms; and the greater challenges for women in accessing reproductive health services due to a lack of economic resources.

34. Tim Martineau, of UNAIDS, emphasized that people living with HIV, like other marginalized and stigmatized groups, faced significant levels of depression linked to the fear of having their status disclosed, and to accessing treatment. Often, discrimination and exclusion were exacerbated by other layers of identity, such as race, sexual orientation and age, leading to further isolation and poorer health outcomes and the added risk of violence and oppression due to widespread stigma. UNAIDS placed human rights and health at the heart of its response to AIDS, by concentrating on prevention, treatment and human rights to fight stigma and discrimination and promote accountability, through a global monitoring system to which approximately 170 countries reported with indicators on discrimination, stigma, and community empowerment. UNAIDS also engaged in global advocacy with other agencies, and supported countries in eliminating stigma and discrimination, improving monitoring, laws, legal literacy and access to justice, raising the awareness of lawmakers, and building the capacity of health-care workers to improve quality of care. Mr. Martineau emphasized the importance of empowering communities as agents of change.

35. Milena Osorio, of ICRC, shared information about the ICRC Mental Health and Psychosocial Support Unit, designed to assist victims of armed conflict, violence and disasters. ICRC interventions were implemented in 105 multidisciplinary programmes in 50 countries and provided a comprehensive package of services in a continuum of care to eliminate stigmatization and discrimination. She specified that her unit supported victims of torture, families with missing relatives, victims of violence and injured persons. It applied inclusive and multidisciplinary approaches to its work with the communities and individuals themselves in designing programmes and providing training to professionals.

and holistic services combining physical and mental health, psychosocial, social and economic support, and protection.

36. Kriti Sharma elaborated on investigations conducted by Human Rights Watch into violations of the rights of persons with psychosocial disabilities in over 25 countries worldwide. Human Rights Watch had found that persons with psychosocial disabilities routinely experienced stigma and discrimination and often did not enjoy basic human rights. She called for the repeal of laws and policies that normalized coercion, including practices of involuntary treatment, electroshock therapy and the use of restraints. She pointed out that stigma may also be pervasive among officials responsible for protecting the rights of persons with psychosocial disabilities, and that even where training was provided on rights and mental health, there was commonly resort to the default response of isolation and force, due to a lack of understanding of support needs. In order to change the mindsets of key actors, they needed to witness first-hand the failings of the current system, but also to become familiar with examples of good practice across all contexts, including humanitarian situations. She called for strengthened cooperation between representative organizations of persons with disabilities and mainstream civil society, in order to tackle multiple and intersecting forms of stigma and discrimination.

37. Peter McGovern shared his experience conducting training for mental health personnel with the WHO QualityRights initiative, which provided a transformative and practical framework translating the rights-based and recovery-orientated approaches enshrined in the Convention on the Rights of Persons with Disabilities into a reality for services and service users. Training necessarily included representation from all stakeholder groups, including health professionals and policy advisers, alongside persons with real-life experience of using services, and entailed engaging in discussions to identify rights denials in services through analysis of case studies, and exploring barriers to change and how to overcome them. The QualityRights initiative addressed resistance, engaged participants and built momentum to support people in a different way. Participants at training sessions concurred that rights-based approaches not only benefited service users but also service providers. Mr. McGovern stressed that the training was a call to action and a guide to how everyday changes could take place, and cited demonstrable changes in attitude to the use of coercive practices in crisis scenarios and in the respect for the individual's right to make decisions for himself or herself after a few days of training. He concluded that the result of training was a shared ownership of service improvement plans — which opened up opportunities for wider culture change promoting a shift towards human rights-based approaches in mental health support.

38. During the interactive dialogue, statements were made by delegates from Australia, the Plurinational State of Bolivia and Peru, and by representatives of the International Network Toward Alternatives and Recovery, Mental Health Europe, Disability Rights International, Salud Mental España, the International Disability Alliance, the World Network of Users and Survivors of Psychiatry, Human Rights Watch, Autistic Minority International, the Hearing Voices Network, the Indonesian Mental Health Association and the Azienda Sanitaria Universitaria Integrata, Trieste. The Peruvian delegate explained the Government's commitment to broadening the role of community centres in mental health care, and the Bolivian delegate stressed that its mental health system also drew on indigenous healing in the national health service, integrating both into a holistic system. The Australian delegate spoke of the compounded discrimination for marginalized populations, such as indigenous peoples and lesbian, gay, bisexual, transgender and intersex persons, and referred to programmes to reduce stigma in health services by building awareness and knowledge about the impact of health issues within those communities. Civil society participants called for the elimination of coercion from mental health services and for effective legal protection and remedies, keeping rights holders, persons with psychosocial disabilities, autistic children and adults at the centre of all initiatives, stressing that their voices must not be substituted by parents or family members who were often empowered by the law to restrict their rights (through forced contraception of women with disabilities under guardianship). Good practices were noted, which included precautionary measures granted by the Inter-American Commission on Human Rights to protect the life and integrity of institutionalized persons with disabilities, leading to the first orders for their integration back into the community; the forthcoming international gathering of the

International Network Toward Alternatives and Recovery, in Kenya in 2019, focusing on dialogue among survivors and users of services, human rights advocates, psychiatrists and practitioners, to develop non-medical and non-coercive approaches to replace traditional psychiatry; and the work of Mental Health Europe to compile practices on alternatives to coercion. The International Disability Alliance warned against the adoption of the draft additional protocol to the Oviedo Convention and Mental Health Europe commended the leadership by Portugal against that instrument.

39. In response, the panellists referred to innovative strategies to promote a positive image of persons with psychosocial disabilities within the media, through awareness-raising and training to combat negative stereotypes and overcome stigma, as well as to multiply their voices and ensure that they remained at the centre of all initiatives.

IV. Conclusions and recommendations

40. In closing, the United Nations Deputy High Commissioner for Human Rights, Kate Gilmore, highlighted the significance of the all-encompassing agenda for inclusion at the critical intersection of human rights, physical and mental integrity and the enjoyment of mental health. She thanked, in particular, the advocates and activists and the persons with real-life experience, who were at the forefront of that transformative process, observing that rights-based change had always come from the vision of those whose rights had been denied. It was to them that the work going forward must be held accountable — to their perspective, views and experience. Ms. Gilmore underscored that many practices that directly violated the principles and the intent of rights persisted, such as forced institutionalization, forced treatment, and criminalization of those with mental health conditions; in those instances, the key friend of rights — the law — was often the key foe. She condemned the unlawful use of the law to dominate and discriminate, and its conversion into a threat to the enjoyment of rights. She concluded by remarking that everyone held the responsibility of knowledge: change was within reach, it was affordable and it was reasonable, and she thus called upon all actors to co-design services and work together to create health-enabling environments.

41. The Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment made concrete recommendations for moving forward. He stressed the pressing need to abolish legislation that allowed persons with disabilities to be institutionalized and to ensure regular review of any decision for institutionalization, including independent monitoring frameworks by human rights experts, national human rights institutions, national preventive mechanisms, civil society and international mechanisms. In addition, States must adopt legislation recognizing the legal capacity of persons with psychosocial disabilities, linked to community living and support. Thus States should facilitate deinstitutionalization by introducing social welfare laws and by the provision of various forms of support services that should be available to persons requiring them. He highlighted the crucial need for guidelines on free and informed consent and the impact of institutionalization, on treatment, and on living conditions for persons with psychosocial disabilities. Furthermore, adequate training and awareness-raising of prison staff was necessary. He underscored the imperative of recognizing violence and abuse perpetrated against persons with disabilities as being a form of torture or other cruel, inhuman or degrading treatment or punishment, in order to afford victims and advocates stronger legal protection for those violations. He concluded by calling for an inclusive society to end marginalization and discrimination.

42. The Special Rapporteur on the rights of persons with disabilities highlighted the strong consensus on the urgent need for change in the area of mental health. The reigning biomedical model had created an increasing gulf of exclusion of persons with psychosocial disabilities, leading to the loss of autonomy and independence and to the entrenchment of forced treatment, violence and forced sterilization. There was a need for community systems and interventions that were evidence-based and were respectful of human rights and of the principle of free and informed consent. She

welcomed the growth of good practices, which confirmed that forced treatment and institutionalization were damaging and unnecessary. She called for greater political commitment from States to implement the way forward by addressing the social determinants of mental health, inclusive of, and in collaboration with, persons with psychosocial disabilities, including through housing support groups, respite care, personal assistance services and other means. The Convention on the Rights of Persons with Disabilities and the 2030 Agenda for Sustainable Development provided the opportunity to build a new narrative based on human rights that fostered inclusion and not segregation. There could be no sustainable development without mental health, and mental health without human rights amounted to oppression. She called upon the United Nations system to internalize the urgent need for change, and to foster cooperation across agencies and cooperation actors. She affirmed that the mental health agenda could not move forward when it continued to ignore the human rights of persons with psychosocial disabilities.

43. The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health noted that the consultation had demonstrated that there was agreement on the root causes of the failure of the system, and on the required actions to address those challenges: eliminating force and biomedical interventions, which led to violations of human rights and bred hopelessness for service users and for service providers who were "forced to use force". To promote mental health, the individual should be in healthy and respectful relationships, including between service providers and users, and forced measures impeded that. He stressed the need for all stakeholders to work together and understand that the best way to promote mental health was to fully integrate the human rights-based approach and foster relationships in all settings. He concluded by stating that the future was a win-win situation for everyone — including psychiatrists, who should let go of the monopoly of power and share responsibility — with stronger commitment by States, and led by a rising critical mass of empowered users.

44. In light of the discussions, the following recommendations were proposed.

45. States should re-examine the biomedical approach to mental health, which maintains the imbalance of power between practitioners and users of mental health services, through a collective process that includes all stakeholders. Users of mental health services, persons with mental health conditions and persons with psychosocial disabilities should play a leading role in developing the conceptual framework that determines mental health services, and in their design, delivery and evaluation.

46. States should ensure that all health care and services, including all mental health care and services, are based on the free and informed consent of the individual concerned, and that legal provisions and policies permitting the use of coercion and forced interventions, including involuntary hospitalization and institutionalization, the use of restraints, psychosurgery, forced medication, and other forced measures aimed at correcting or fixing an actual or perceived impairment, including those allowing for consent or authorization by a third party, are repealed. States should reframe and recognize these practices as constituting torture or other cruel, inhuman or degrading treatment or punishment and as amounting to discrimination against users of mental health services, persons with mental health conditions and persons with psychosocial disabilities. States should ensure their enjoyment and exercise of legal capacity on an equal basis with others by repealing laws that provided for substituted decision-making, and should provide: a range of voluntary supported decision-making mechanisms, including peer support, respectful of their individual autonomy, will and preferences; safeguards against abuse and undue influence within support arrangements; and the allocation of resources to enable and ensure the availability of support.

47. States should implement people-centred and human rights-based support and services, including on mental health, which are community-based, participatory and contextually and culturally respectful and which enable and facilitate participation in society. These services should be available in the communities where people live, ensuring that their family and personal networks are not jeopardized but are

promoted and strengthened. States should evaluate multiple strategies for the implementation of such services, building partnerships with users, including user-led services, such as peer support, and should make available accessible services offering non-coercive spaces, support and respite, including during crisis situations, for example medication-free spaces.

48. States should strengthen data-collection efforts and undertake and invest in evidence-based and participatory research, inclusive of users of these services and of persons with psychosocial disabilities, in order to: identify the multiple and intersecting forms of discrimination operating in the context of mental health and evaluate the impact of services; and design and make available accessible and affordable non-coercive spaces, support and respite, respectful of the individual's free and informed consent. International cooperation actors should be encouraged to provide funding and technical assistance to fulfil these efforts, and to refrain from implementing or supporting projects or research contravening the Convention on the Rights of Persons with Disabilities.

49. States should revise and adopt legislation to combat stigma and discrimination against users of mental health services, persons with mental health conditions and persons with psychosocial disabilities. States should implement training programmes, such as the WHO QualityRights initiative, to build capacity among mental health professionals, practitioners and policymakers on how to implement a human rights-based and recovery approach in accordance with the Convention on the Rights of Persons with Disabilities. Complementary to this, States should design and implement information campaigns and programmes to raise community awareness, in order to eliminate negative stereotypes, labeiling, stigma and discrimination against users of mental health services, persons with mental health conditions and persons with psychosocial disabilities, with their central involvement in the design and delivery across training and awareness-raising programmes.

50. States should ensure that users of mental health services and persons with psychosocial disabilities have access to justice, including through maintaining their legal capacity within proceedings to challenge human rights violations in mental health contexts, and ensure that redress and reparation is provided for the individual while addressing systemic change through legal and policy reform and capacity-building.

51. States should design and implement policies and programmes addressing the underlying determinants of mental health — among others, multiple and intersecting forms of discrimination, the right to social protection, access to housing and water and sanitation, the right to work, and the right to live independently and be included in the community.

52. States should adopt immediate steps towards deinstitutionalization, by developing action plans in a participatory manner, and using the maximum of their available resources, including through international cooperation. States should recognize in the law the right to access support services to enable independent living and inclusion in the community, and ensure that support is provided and arranged according to the individual's will and preferences. Deinstitutionalization plans should incorporate the development of support services in the community that do not replicate biomedical or coercive approaches.

53. Given that, throughout the consultation, participants expressed their concern about the ongoing process within the Council of Europe to draft an additional protocol to the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine (the Oviedo Convention), indicating that the draft additional protocol on "the protection of human rights and dignity of persons with mental disorder with regard to involuntary placement and treatment" contradicted the Convention on the Rights of Persons with Disabilities, member States of the Council of Europe should evaluate the potential impact of the adoption of this instrument vis-à-vis their international obligations under the Convention on the Rights of Persons with Disabilities and other human

rights law, specifically regarding the individual's right to free and informed consent to treatment within mental health services. All States parties to the Convention on the Rights of Persons with Disabilities should undertake a review of their obligations before adopting legislation or instruments that may contradict their obligations to uphold the rights of persons with disabilities.

Annex

List of participants

States Members of the Human Rights Council

1. Australia, Brazil, Chile, China, Croatia, Ecuador, Germany, Hungary, Japan, Mexico, Panama, Peru, Slovakia, Slovenia, Spain, Switzerland, Togo, Ukraine, United Kingdom of Great Britain and Northern Ireland, Venezuela (Bolivarian Republic of).

States Members of the United Nations

2. Bolivia (Plurinational State of), Bulgaria, Canada, Colombia, Cyprus, France, Gabon, Greece, Israel, Italy, Lithuania, Luxemburg, Maldives, Monaco, New Zealand, Norway, Poland, Portugal, Romania, Thailand, Turkey.

Intergovernmental organizations

3. European Union (EU), International Committee of the Red Cross (ICRC), International Labour Organization (ILO), Parliamentary Assembly of the Council of Europe, United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF), World Health Organization (WHO).

Non-governmental organizations in consultative status with the Economic and Social Council

Special

4. Association for the Prevention of Torture (APT), CERMI Spanish Committee of Representatives of People with Disabilities, Disability Rights International, Du Pain Pour Chaque Enfant, Fundacion Vida — Grupo Ecologico Verde, International Disability Alliance, Users and Survivors of Psychiatry in Kenya (USP-K), World Network of Users and Survivors of Psychiatry (WNUSP).

Other non-governmental organizations

African Disability Forum (ADF), Autistic Minority International, Akershus University Hospital, Azienda Sanitaria Universitaria Integrata Trieste — ASUITs, Citizens Commission on Human Rights, Centre for inclusive Policy, CEPGL, Citizens Commission on Human Rights Europe, Contrôleur général des lieux de privation de liberté, Indonesian Mental Health Association, International Network toward Alternatives and Recovery, Mental Health Europe, Psycovery, Salud Mental España, SHI Swiss Health Invest, Support-Fundació Tutelar Girona, The Global Campaign for Mental Health, Transforming Communities for Inclusion Asia, Universidad de Chile, University of Glasgow, We Shall Overcome.